Living Will Declaration

Instructions
Consult this column for help and guidance.

To My Family, Doctors and All Those Concerned With My Care

This Declaration sets forth your directions regarding medical treatment.

I, _____,
being of sound mind make this statement as a directive to be followed if I become unable to participate in decisions regarding my medical care.

If I should have an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Montana Rights of the Terminally Ill Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

You have the right to refuse treatment you do not want and you may request the care you want.

These directions express my legal right to refuse treatment. Therefore, I expect my family, doctors, and everyone concerned with my care to regard themselves as legally and morally bound to act in accord with my wishes and in so doing, to be free of any legal liability for having followed my directions.

You may list specific treatment you do <u>not</u> want. For example,
Cardiac resuscitation
Mechanical breathing
Kidney dialysis
Artificial feeding/fluids by tubes
Otherwise, your general statement set forth in the Declaration will stand for your wishes

I especially do <u>not</u> want:

_____

_____

_____

_____

You may want to add instruction for care you <u>do</u> want. For example, do you want pain relief medications or do you prefer to die at home if possible?

However, I <u>do</u> want:

_____

_____

_____

(Please complete other side)

REV 03/06 30096291

Sign and date here in the presence of two adult witnesses, who should also sign.

Keep the signed original with your personal papers at home. Give signed copies to doctors, family, proxy designee, and the medical records department of those hospitals in which you are likely to be hospitalized.

Review your Declaration from time to time. Initial and date it to show it still expresses your intent.

Signed this____day of_____,20____

_____
Your Name

_____
Your Signature

_____
Date of Birth

_____
City, County and State of Residence

_____
Witness

_____
Witness

2800 Tenth Avenue North
P.O. Box 37000
Billings, MT 59107